

American Medical Association

Physicians dedicated to the health of America

AMA Physician Profile Unit
515 North State St
Chicago, IL 60610

Telephone: 312 464-5199
Fax: 312 464-5900

AMA Physician Profile Order Form -- Physician Use Only

Complete and send this form to the American Medical Association (AMA) at the above address. Profiles also can be ordered online through **AMA ePhysician Profiles** located at <http://www.ama-assn.org/AMAPhysicianProfiles>. AMA Customer Service is available for ordering assistance at 800-665-2882 or 312-464-5199, Monday through Friday, 8:30am - 4:45pm CT.

*****Join or renew your AMA membership today---call 800-AMA-3211*****

Indicate AMA Membership Status: _____ Member Physician _____ Nonmember Physician

Membership Type	Standard Mail Service* (within 10 business days)	Express Service* (within 5 business days)
AMA Member Physician	No charge	\$6 per profile
Nonmember Physician	\$26 per profile	Not available

***Prices are subject to change without advance notice.**

Credit card payment is preferred as check payments may extend processing time. Checks should be made payable to the American Medical Association, Remittance Control Area/PPS, Accounting Department, PO Box 109054, Chicago, IL 60610. Orders faxed to the AMA must include credit card information for billing purposes.

___ VISA ___ American Express ___ MasterCard Charge Amount: \$ _____

Credit Card Number _____ Expiration Date: ____/____/____

Name on Credit Card: _____

Billing Address: _____

Approval Signature _____ Daytime Telephone: _____

Part 1: AMA Physician Profile Delivery Information

Please send my profile to the following state licensing or medical specialty board:

Board Name: _____

NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

Physician Name (first, middle, last, suffix) _____

Place of Birth _____ Date of Birth ____/____/____ Social Security Number _____

E-mail Address _____ Medical Education Number (optional) _____

Preferred Mailing Address _____

City, State, Zip Code _____ Telephone Number (____)____-____

The above address is my OFFICE ___ HOME ___ OTHER ___

If address is home or other, please complete this section.

Primary Office Address _____

City _____ State _____ Zip Code _____ Office Telephone Number (____)____-____

Part 3: Medical Education and Other Information

Medical School of Graduation

Year of Graduation

DEA Number

ECFMG Number**Residency Training**

Residency Training (institution/hospital name, location, and years)

Hospital Admitting Privileges

Hospital Name

City/State

Group Practice Affiliation(s)

Group Practice Name

City/State

Physician Agreement**Agreement must be signed in order to process your request.**

AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X _____
Signature

_____/_____/_____
Date